State of Nebraska
DHHS Division of Public Health, Office of Nursing and Nursing Support
P.O. Box 94986 - Lincoln, NE 68509-4986
Telephone: (402) 471-4910

RENEWAL NOTICE

Your registration as a _____ expires _____. The renewal fee of **$18.00,** this renewal notice and documentation of competency are required for renewal.

Registration # **:**

Name: _____

Address: _____

_____

TWO YEAR RENEWAL

YOU MUST CHECK A BOX BELOW:

☐ ACTIVE $18.00 (Renewal)

☐ INACTIVE No fee (Non-Renewal)

Name & Address Changes: If your name or address is incorrect, cross out incorrect information and print correction. For name changes, you must submit a photocopy of marriage certificate, court order, etc. If not submitted, the registration will be issued in the name as printed above.

Internet: All Nebraska Credentialing Information is public information, and is now on the Internet under **http://dhhs.ne.gov/publichealth/Pages/lis_lisindex.aspx**

Make Checks Payable to: LICENSURE UNIT **- SUBMIT FEE AND THIS RENEWAL NOTICE IN THE ENCLOSED ENVELOPE.**

Expired Registration: You may not function as a _____ after your registration has expired on _____ . To ensure renewal of your registration before the expiration date submit required fee, renewal notice and documentation of competency assessment at least 30 days prior to expiration.

You Must Answer the Following Question:

If you fail to answer this question, your renewal will not be processed and will be returned to you as incomplete. This question relates to the time since you signed the last application or renewal application.

Have you been convicted of a misdemeanor or felony other than a minor traffic violation?	☐ Yes	☐ No

If you answered YES to the above, you **MUST** complete this section:

List the type of conviction(s) along with the date of occurrence and county/state in which the conviction occurred. Please include a brief description of the conviction including what the conviction was for, what happened and who was involved. Attach additional sheet of paper if necessary. Please note that a conviction is not necessarily a disqualification for placement on the registry. You **Must** submit **certified** copies of the following for each conviction: All Charges; All Pleas; All Sentencing & Probation Orders; and All Documentation pertaining to completion of probation requirements. If you do not submit the documents, your renewal will not be processed and will be returned to you as incomplete.

Date of Conviction County/State Type of Conviction

_____

_____

Please verify the following information so we may update and/or correct our current Credentialing Information:

Social Security Number: _____
Date of Birth: _____
Place of Birth: _____
Telephone Number: _____

See other side for Attestation of Lawful Presence in the United States and Documentation of Competency Assessment Form.
If you fail to complete the Attestation of Lawful Presence or if the Competency Assessment is not completed correctly, your renewal will not be processed and will be returned to you as incomplete.

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Applicant's Attestation of Lawful Presence in the United States:

For the purpose of complying with §§4-108 through 4-114, I attest as follows:

Please check the appropriate choice below:

☐ I am a citizen of the United States

☐ I am a qualified alien under the Federal Immigration and Nationality Act, my Immigration status and alien number are as follows _____, and I agree to provide a copy of my United States Citizenship and Immigration Services documentation upon request.

I hereby attest that my response and the information provided on this form and any related applications for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Application Attestation: I further attest that:

1. I have read the application or have had the application read to me;
2. All statements on the application are true and complete; and
3. I am of good moral character

Print Name: _____

Signature: _____ Date: _____

Documentation of Competency Assessment
This is to certify that

_____ _____
Name of Medication Aide Social Security #

has successfully demonstrated each of the competencies as identified in Title 172 NAC 96, Section 005
on _____
(Date)

PLEASE READ THE FOLLOWING SECTIONS CAREFULLY BEFORE COMPLETING

To be completed by Licensed Health Care Professional conducting the competency assessment and/or directing a registered Medication Aide to conduct the competency assessment

_____ _____ _____
Signature of Licensed Health Care Professional Profession License #

_____
Place of employment of Licensed Health Care Professional

_____
Work telephone number of Licensed Health Care Professional

IF APPLICABLE to be completed by registered Medication Aide conducting the competency assessment

_____ _____
Signature of registered Medication Aide conducting the competency assessment Registry #:

_____
Place of employment of Medication Aide conducting the competency assessment

_____
Work telephone number of Medication Aide conducting the competency assessment

Department of Health & Human Services
Division of Public Health, Licensure Unit
PO Box 94986, Lincoln NE 68509-4986
Telephone # 402-471-4910 or 402-471-4364 – Fax # 402-471-1066